

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2022
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 09/13/2022 |
| NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| {F 000} | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/5/22. This visit included a PSR to the Investigation of Complaints IN00384672, IN00384824, and IN00387286 completed on 8/5/22.</p> <p>Complaint IN00384672 - Corrected.</p> <p>Complaint IN00384824 - Corrected.</p> <p>Complaint IN00387286 - Corrected.</p> <p>Survey dates: September 12 and 13, 2022</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census Bed Type: SNF/NF: 133 Total: 133</p> <p>Census Payor Type: Medicare: 6 Medicaid: 120 Other: 7 Total: 133</p> <p>Aperion Care Tolleston Park was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00384672, IN00384824, and IN00387286.</p> <p>Quality review completed on 9/14/22.</p> | {F 000} | | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | TITLE | | (X6) DATE |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2022
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 09/13/2022 |
| NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK | | STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | |